

Private Health Insurance in OECD Countries

What is the role of private health insurance in OECD countries?

Does private health insurance improve access to care and cover?

Does it create more choice and responsiveness?

Does private health insurance promote high-quality care?

Has it helped relieve cost pressures?

Does private health insurance make health systems more efficient?

How can policy makers use private health insurance to improve performance?

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Introduction

Health spending in OECD countries averages more than 8% of gross domestic product (GDP) and the share is rising. Overall, some three-quarters of that spending is publicly financed. Private health insurance accounts, on average, for only a quarter of private-sector financing, although there is great cross-country variation. In a third of the OECD member countries at least 30% of the population has private health insurance, while market size is negligible in nearly as many countries. Private health insurance also plays a variety of roles, ranging from primary coverage for particular population groups to a supporting role for public systems.

Policy attitudes towards private health insurance also vary. Some governments do not see private health insurance as an important or desirable component of their health systems. Others consider it to be a pillar of the health system. Governments look to private health insurance to supplement public financing, or in some cases to replace it, for a variety of reasons. It may simply be a matter of finding an alternative source of financing to increase the capacity of the health system, or a means to achieve other health policy goals, such as greater individual responsibility for health-care funding.

Private health insurance can help governments attain health system performance goals, but can also put them at risk. The effect depends, in part, on the role of private health insurance, in terms of market size and function with respect to public systems. In countries where private health insurance plays a prominent role, it can be credited with injecting resources into health systems and helping to make them more responsive. However, it has also given rise to considerable equity and cost control challenges in most of those same countries.

This Policy Brief looks at trends in private health insurance in OECD countries and at the opportunities and challenges created by these markets. It also depicts useful practices that can help policy makers employ private resources to help them achieve health policy goals.

What is the role of private health insurance in OECD countries?

In the United States, the Netherlands and Germany, private health insurance is a source of *primary* coverage for population groups without access to public health cover. Under the US system, in which public coverage through Medicare and Medicaid is restricted to the elderly, disabled and certain poor groups, 72% of the population has some form of private health insurance. In the Netherlands, nearly a third of the population – those in the upper-income bracket – is excluded from publicly funded insurance; almost all of those excluded buy private primary cover. Germany, on the other hand, is the only OECD country allowing individuals above an income threshold to opt out of social health insurance.

In Australia, Ireland, New Zealand and the United Kingdom, where privately funded providers operate in

parallel to the public delivery system, private health insurance *duplicates* existing public universal coverage, offering a private alternative. Nearly half of the Australian and Irish populations purchase a private health insurance policy, making these the largest duplicate markets across the OECD.

Private health insurance also *complements* financing from public programmes in many OECD countries by covering cost sharing under those arrangements. This type of coverage predominates in France, where complementary insurance reaches over 90% of the population. In the United States, individuals eligible for Medicare can buy policies covering co-payments or other service gaps in the public programme.

Finally, in many OECD countries private health insurance *supplements* public systems by financing goods and services that are excluded from public coverage. Private health insurance is purchased by 65% of the

Table 1. Population covered by private health insurance and by public coverage systems, 2000

	PHI (% of total health expenditure)	Population covered by PHI (%)	Types of private coverage		PHI (% of total health expenditure)	Population covered by PHI (%)	Types of private coverage
Australia	7.3	44.9 40.3	Duplicate, Complementary Supplementary	Korea	n.a.	n.a.	Supplementary
Austria	7.2	0.1 31.8	Primary (Substitute) Complementary, Supplementary	Luxembourg	1.6	2.4	Complementary, Supplementary
Belgium	n.a.	57.5	Primary (Principal) Complementary, Supplementary	Mexico	2.5 (2001)	2.8	Duplicate, Supplementary
Canada	11.4	65.0 ^(e)	Supplementary	New Zealand	6.3	35	Duplicate, Complementary, Supplementary
Czech Republic	0 ^(e)	negligible	Supplementary	Norway	0 ^(e)	negligible	n.a.
Denmark	1.6	28 (1998)	Complementary, Supplementary	Netherlands	15.2	92 of which: 28.0 64 ^(e)	Primary (Principal) Supplementary
Finland	2.6	10	Duplicate, Complementary, Supplementary	Poland	n.a.	negligible	Supplementary
France	12.7	92	Complementary, Supplementary	Portugal	1.5 (1997)	14.8	Duplicate, Complementary, Supplementary
Germany	12.6	18.2 of which: 9.1 9.1	Primary (Substitute) Supplementary, Complementary	Slovak Republic	0 ^(e)	negligible	Supplementary
Greece	n.a.	10	Duplicate, Supplementary	Spain	3.9	13 of which: 2.7 10.3	Primary (Substitute, Principal) Duplicate, Supplementary
Hungary	0.2	negligible	Supplementary	Sweden	n.a.	negligible	Complementary, Supplementary
Iceland	0 ^(e)	negligible	Supplementary	Switzerland	10.5	80	Supplementary
Ireland	7.6	43.8	Duplicate, Complementary, Supplementary	Turkey	0.7 (1994)	< 2	Complementary, Supplementary
Italy	0.9	15.6 (1999)	Duplicate, Complementary, Supplementary	United Kingdom	3.3 (1996)	10.0	Duplicate, Supplementary
Japan	0.3	negligible	n.a.	United States	35.1	71.9	Primary (Principal) Supplementary, Complementary

Notes: Negligible indicates a proportion covered of less than 1%; PHI: Private health insurance; n.a. indicates not available; (e) Estimated.
Source: OECD (2004). Private Health Insurance in OECD countries.

population in Canada, where the supplementary role is the sole permitted function of private health insurance in most provinces, while in the Netherlands nearly all of the population with social health insurance purchases supplementary insurance. In Switzerland, 80% of the population supplements basic mandatory health coverage with a voluntary private health insurance policy.

Types of private health insurance

Private health insurance is used at different levels, and for different reasons, in individual OECD countries. In some countries it is the primary source of health coverage for at least part of the populations; in others it duplicates the public system, offering a private alternative; and finally it acts as a complement or supplement to public programmes.

The variety of roles and market sizes of private health insurance in OECD countries (see table 1) arises from several factors. Many countries with large markets have a tradition of private health financing and insurance markets. Statutory health coverage and delivery systems affect which services, providers and population groups private health insurance covers, and government attitudes towards private health insurance markets shape their structure and dimension. The presence of employer-based private health insurance often contributes to explain high levels of private coverage (as in the United States, Canada, and France). Consumer desire to obtain more and faster care, or the level of satisfaction with publicly funded services also influences demand for private health insurance. ■

Does private health insurance improve access to care and cover?

The contribution of private health insurance to improving access to health coverage and health care has varied depending on how large a private market has developed and how broad a pool of risks it covers.

For example, public health insurance markets have not developed enough to provide significant financial protection in Korea, Mexico, Greece or Turkey, despite large gaps in the population or services covered by public systems. This could be the result of several factors, ranging from lack of a history of health insurance markets to premium affordability considerations.

Even where private markets have developed, access to coverage remains a key challenge. Where private health insurance is under little or light regulation, higher-risk individuals have often faced difficulty in obtaining policies at an affordable price. Several OECD countries have introduced measures to promote availability and affordability of insurance, which apply either to the entire private health insurance market or to that part of it servicing high-risk groups.

Clearly, when public cover is not comprehensive or universal, private health insurance has enhanced access to care. But such access is often inequitable, largely because private health insurance is typically purchased by high-income groups.

In duplicate systems, for example, private health insurance provides a level of care, choice and speed of access above that offered by public systems, to those who can afford to pay for it. Privately insured patients may benefit, in particular, by obtaining shorter waiting times for elective surgery. But there is no clear evidence that waiting times are also reduced in the public sector, the only choice for those on lower incomes.

There are also equity issues arising from the fact that in some countries the private health-care sector pays providers more than they could earn in the public system. While this encourages high service volumes and productivity in the private sector, the quality and quantity of publicly financed services might suffer as a consequence, especially when providers' responsibility and obligations to public patients are not clearly defined and monitored. To avoid such problems, policy makers in some systems have introduced regulations limiting the possibility for privately insured persons to enjoy a superior level of care and choice, as in the case of the Netherlands. This minimises the risk of creating two levels of health care according to insurance status and, therefore, ability to pay. ■

Does it create more choice and responsiveness?

Private health insurance has enhanced consumer choice and the responsiveness of health systems in many OECD countries. First, the opportunity to buy private health insurance in itself offers consumers an additional level of choice with respect to financing health-care services and providers on an out-of-pocket basis. Second, private health insurance has improved individuals' choice over health providers

and timing of care in most countries with duplicate markets – although the scope of this added choice depends upon the freedom of choice already existing within public systems. Third, most private health insurance markets offer a wide array of products to consumers, allowing them to tailor their risk and product preferences.

Clearly, for consumers to exercise meaningful choice, insurers' marketing and product information materials need to be clear and enable comparisons across the market. Consumers have complained about the quality of product information at the point of sale in some countries. Governments or private organisations have intervened by disseminating comparative information on the quality, features and cost of health plans in some countries, such as the United States and Switzerland.

But an abundance of product choices can make it harder for higher-risk patients to find cover, to the extent it results in segregation of the market by risk level. To avoid the problem of vulnerable groups being priced out of the private health insurance market, as has occurred in some OECD countries, some policy makers have limited the scope for insurers' flexibility and innovation. For example, they have regulated the minimum benefits that insurers must cover, required insurance products to be standardised, or limited the extent to which insurers can refuse cover and rate premiums on the basis of individual risk. ■

Does private health insurance promote high-quality care?

Private health insurance has had only a minimal impact on the quality of care in most OECD countries, since private insurers have not usually engaged in significant efforts to influence the quality of the services they finance. The lack of effort is due to a combination of factors, ranging from lack of regulatory and financial incentives for insurers, to a desire not to restrict individual choice, as well as resistance from health-care providers to the introduction of a new source of influence on decisions over appropriateness of care.

The United States has been the only OECD country where some private insurers, known as managed care plans, have been substantially involved in efforts to influence some aspects of care delivery. Despite indications of some effectiveness, the overall evidence of the impact on quality of care is mixed: such plans do not appear to have fundamentally changed clinical

processes. Payment incentives that do not consistently reward plans' or employers' efforts to improve quality and inadequate quality-measurement and reporting systems, explain the still small and non-systematic impact of private health insurance on quality improvements in the United States. ■

Has it helped relieve cost pressures?

Policy makers often look to private health insurance markets as an alternative or additional source of funding for publicly financed health systems, especially when these budgets are stretched to capacity. Yet health systems in OECD countries continue to be predominantly financed from public sources, which account, on average, for 72% of total health expenditure, compared to 6.3% for private health insurance and 19% for out-of-pocket payments. Only in the United States does private health insurance exceed a third of total health expenditure, at 35%, while it goes above 10% only in the Netherlands, Canada, France, Germany and Switzerland (figure 1).

Whatever the role played in a health system, private health insurance has added to total health expenditure. Most OECD countries apply less government control over private sector activities and prices, compared to public programmes and providers. Private insurers tend to have less bargaining power over the price and quantity of care as compared with public systems, particularly single-payer ones. Countries that have multiple sources of primary coverage, including those with significant private health insurance market size, tend to be those with the highest total health spending levels per capita, such as the United States, Switzerland, Germany and France. ■

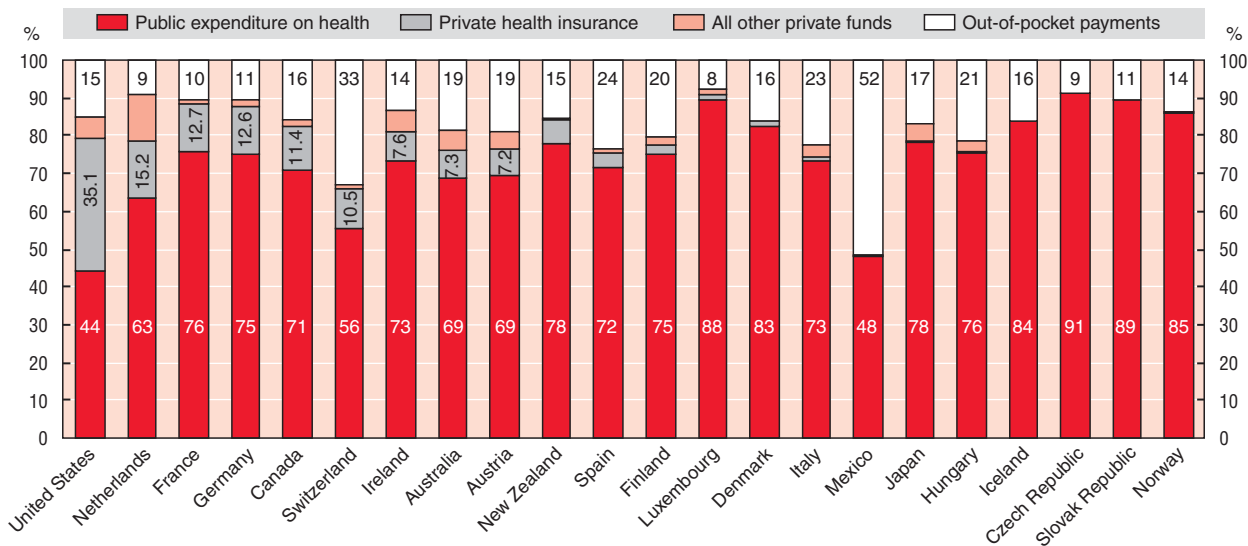
Has private health insurance shifted cost from public systems?

There are a number of reasons why private health insurance has not significantly reduced public financing burdens. For one thing, people with private insurance often continue to rely upon publicly financed hospital services in duplicate markets. Privately financed hospitals have often focussed on a limited range of elective services, leaving the responsibility for more expensive services or populations to public programmes.

Second, in OECD countries that have restricted eligibility for public insurance to lower-income and vulnerable groups, leaving the rest to buy primary private health insurance (the United States, the Netherlands,

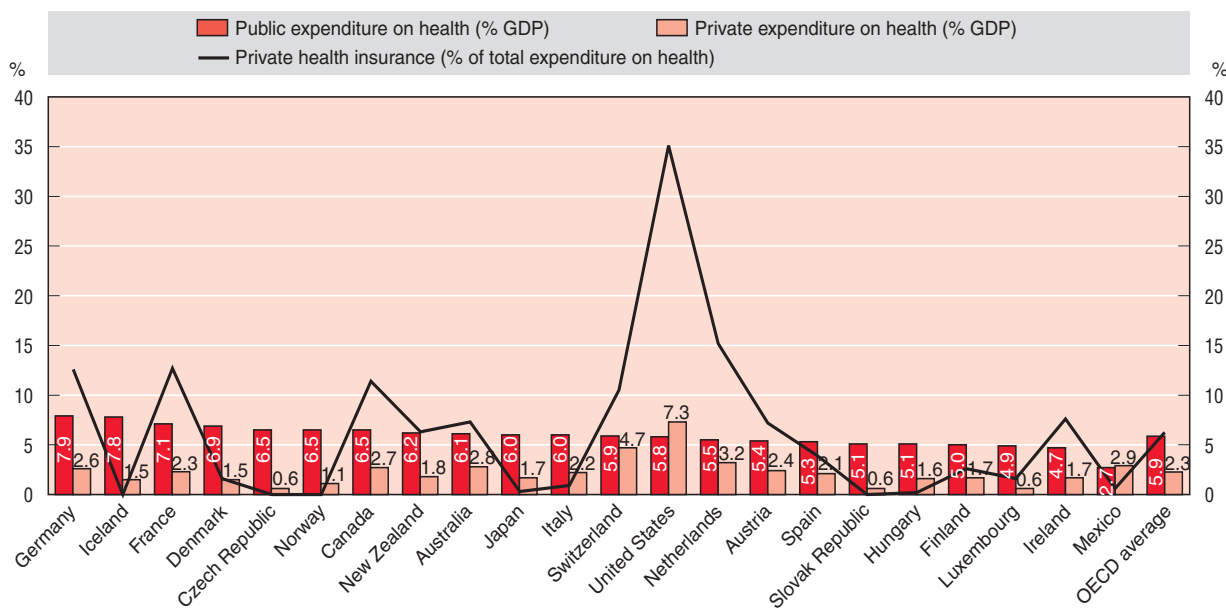
Private Health Insurance in OECD Countries

Figure 1. Health expenditure by source of health financing, 2000



Note: Countries are ranked by decreasing size of private health insurance.
 Source: OECD Health Data, 2003, 2nd Edition.

Figure 2. Public and private health spending as a share of GDP and expenditure financed by private health insurance, 2000



Source: OECD Health Data, 2003, 2nd Edition.

Germany), public spending on health as a percentage of GDP is not lower than that of many countries that provide universal public coverage (figure 2). This can be partly explained by the concentration of health-care cost among a small fraction of the population that is generally publicly insured – such as the elderly, chronically ill, and long-term disabled.

Third, de-listing of services from public coverage, another strategy to shift cost onto the private sector, has generally remained confined to less expensive services, which may be paid for out-of-pocket or through supplementary private health insurance policies.

In some cases, private health insurance has actually added to public expenditure on health or public costs generally. Where private health insurance covers cost sharing on public coverage systems, as in France, the resulting increases in use of services raise the cost of publicly financed health systems. In addition, countries that grant significant public subsidies to private health insurance, as Australia and the United States, have seen a reduction in government revenue or an increase in public cost. ■

Does private health insurance make health systems more efficient?

While private health insurance is often viewed as a tool to enhance efficiency, the evidence shows it has made only a small contribution so far. Several reasons explain this performance. Insurers need to sustain high administrative costs in order to attract and retain clients, provide them with a diversity of insurance plans, and negotiate multiple contractual relationships with providers. Furthermore, in several OECD countries, insurers have had few incentives to manage care cost-effectively, due to a combination of desire not to restrict individual choice, providers' resistance, and the cost of implementing such action.

Difficulties in extracting efficiency improvements from private health insurance markets can also come from the way in which insurers compete. In several OECD countries, insurers are confronted with limited competitive pressures as there is little consumer mobility across insurers. It is attractive for insurers to employ cost-shifting and selection of risk as a means of insurer competition and protection against adverse selection, rather than improving the cost-effectiveness of care provided to clients. Finally, the lack of “vibrant” price and quality competition among providers inhibits market forces in insurance markets, for

example if providers exercise dominant market power, leading them to demand high prices for health services and shielding them from insurers' pressure to improve quality or cost-effectiveness of care. ■

How can policy makers use private health insurance to improve performance?

A system based on competing primary insurers can improve responsiveness and consumer choice, but at increased cost. Where private health insurance is the primary source of coverage for certain population groups, it may be particularly challenging to assure adequate access to coverage for vulnerable populations. Regulations to address market failures and promote equity have costs, in terms of government resources and diminished insurer flexibility to innovate.

Duplicate private health insurance markets can serve as a lever to improve systems' responsiveness when policy makers consider it appropriate to ration public health expenditure according to individuals' willingness to pay. Yet this generally results in differences in access to care and coverage according to insurance status. The degree of differential access that occurs, and the extent to which these access variations are considered equity challenges vary by country. In addition, duplicate private health insurance has not significantly reduced public health expenditure.

In the presence of significant cost sharing within public systems, complementary private health insurance helps ensure access to needed care. However, full private coverage of such cost sharing encourages insured individuals and providers to increase utilisation. Unless some cost sharing is retained to encourage individual cost awareness, private health insurance hinders efforts to control public systems' outlays.

Finally, supplementary coverage provides individuals with an opportunity to buy financial protection against risks associated with services not covered by public programmes. Removing public sector coverage of some health services helps reduce public expenditure. However when utilisation of supplementary services is linked to publicly financed services, this increases public costs. As private health insurance markets generally have less comprehensive reach than does public coverage, decisions to de-list services need also to weigh the desired reductions in public sector cost against the equity implications of lack of public coverage.

Policy makers have a number of tools at their disposal to address these challenges.

- Access-related standards help to promote insurance coverage for high-risk persons and may be particularly useful in primary private health insurance markets. The need for these interventions often depends on the comprehensiveness of the benefits they apply to, and the extent to which the costs of any high-risk coverage are cross-subsidised by other private insurers or by other financing sources. If publicly funded systems provide adequate access to needed health services, policy makers may question the need for such interventions in their markets.
- Although private health insurance can create disparities in access to health care between those with and those without private cover, policy makers can intervene by regulating the roles that private insurance is allowed to have; regulating price differentials between publicly and privately financed medical practice; specifying providers' obligation to public patients and monitoring compliance with those obligations.
- Maintaining at least some modest cost sharing in public systems that cannot be insured against helps to minimise undesired cost consequences of complementary private health insurance.
- Policy makers can maximise effective choice within private health insurance markets by fostering readily understood comparative information and product disclosure requirements. Some limits on benefit packages may be appropriate, particularly if products are sold to vulnerable population groups. Yet,

benefit standardisation reduces insurers' ability to innovate and tailor products to individuals' demands.

- Policy makers can maximise cost shifting between the public and private sector by encouraging private insurees not to rely on public systems for privately covered services. They also need to assess whether subsidies towards private markets are self-financing and appropriate by weighing carefully their cost and benefit. Applying cost-control measures within the overall health system, including the private sector, improves the ability to control cost within private markets.
- Incentives or regulatory requirements might facilitate efforts to improve cost-effectiveness of care. Examples include removing insurers' obligations to contract with all providers, or providing incentives for insurers to be involved in preventative care or care management. Improved consumer information could facilitate effective competition among insurers. Systems to compensate insurers with a worse risk structure can help reduce insurers' incentives to select good risks, thus promoting equitable risk pooling. However, they can also reduce or remove incentives for insurers' efficiency. ■

For more information

For more information on the OECD's work on private health insurance, contact Francesca Colombo, e-mail: francesca.colombo@oecd.org; tel.: + 33 1 45 24 93 60. ■

For further reading

- **Private Health Insurance in OECD Countries**, OECD, 2004. ISBN: 9264015639.
- **Towards High-Performing Health Systems**, OECD, 2004. ISBN: 9264015558.
- **Towards High-Performing Health Systems – Policy Studies**, OECD, 2004. ISBN: 9264015590.
- **Private Health Insurance in OECD Countries: the Benefits and Costs for Individuals and Health Systems**, by Francesca Colombo and Nicole Tapay, OECD Health Working Papers No. 15. Free on Internet: www.oecd.org/els/health/workingpapers.
- **Private Health Insurance in France**, by Thomas C. Buchmueller and Agnes Couffinhal, OECD Health Working Papers No. 12, 2004. Free on Internet: www.oecd.org/els/health/workingpapers.
- **The Slovak Insurance System and the Potential Role for Private Health Insurance. Policy Challenges**, by Francesca Colombo and Nicole Tapay, OECD Health Working Papers No. 11, 2004. Free on Internet: www.oecd.org/els/health/workingpapers.
- **Private Health Insurance in Ireland. A Case Study**, by Francesca Colombo and Nicole Tapay, OECD Health Working Papers No. 10, 2004. Free on internet: www.oecd.org/els/health/workingpapers.
- **Private Health Insurance in Australia. A Case Study**, by Francesca Colombo and Nicole Tapay, OECD Health Working Papers No. 8, 2003. Free on Internet: www.oecd.org/els/health/workingpapers.
- **Private Health Insurance in the Netherlands. A Case Study**, by Nicole Tapay and Francesca Colombo, forthcoming.
- More information on *private health insurance* is available at: www.oecd.org/health, by clicking on “OECD Health Project” and then on the “OECD Study on Private Health Insurance”.

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